Medical Benefits - CHANGE / TERMINATION FORM

ICSVEBA

EMPLOYEE INFORMATION

Last Name	First Name	Initial	Social Security Number

REASON FOR REQUESTED CHANGE

Benefits Change Effective Date: / /

1. Addition of Dependent Coverage — Date of Marriage, Birth, Adoption
   - ☐ Spouse ☐ Natural Child
   - ☐ Adopted Child ☐ Stepchild
   - / /

2. Termination of ALL Dependent Coverage - Reason — Effective Date / /

3. Termination of Named Dependent(s) — Effective Date
   - ☐ Spouse ☐ Child(ren)
   - Name(s)
   - Reason(s)
   - / /

4. Change Plan Option (Open Enrollment Only) — Effective Date
   - From: _____ To: _____
   - / /

5. Change Status — Effective Date
   - ☐ Retiree ☐ COBRA
   - / /

6. Termination of Life Insurance — Effective Date
   - ☐ Basic Life ☐ AD&D ☐ Dependent Life
   - / /

7. Reinstate Coverage — Effective Date
   - ☐ ALL ☐ Employee ☐ Dependent
   - / /

8. Cancel ALL Coverage — Effective Date
   - ☐ Termination of Employment ☐ Leave/Lay Off
   - / /

9. Other Changes
   - ☐ Name ☐ Address

Name

Address

City Zip Country

EMPLOYEE ELECTION

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

NETWORK SELECTED

Anthem Blue Cross JAA

COVERAGE SELECTED

- ☐ Comprehensive Option
- ☐ Basic Option
- ☐ COB
- ☐ Bronze Option

EMPLOYER USE ONLY

Name of EMPLOYER (District): Seeley Union School District

Employment Date

Employment Status
- ☐ Full Time ☐ Retiree ☐ COBRA (attach form)
- ☐ Part Time ☐ Disabled ☐ ICSIS #

HUB OFFICE USE ONLY

Initials

Date Received: _____

Date Processed: _____

Initials

VB:_____ DB:_____ DHS:_____ ADJ:_____

EMPLOYEE MUST SIGN HERE

Employee Signature Date

X

Use this space to list eligible dependent changes. Last name required if different from employee's

Spouse's Name	Date of Birth / /	Sex ☐ M ☐ F	SSN	
Dependent's Name	Date of Birth / /	Sex ☐ M ☐ F	SSN	Relationship ☐ Son ☐ Daughter Other
Dependent's Name	Date of Birth / /	Sex ☐ M ☐ F	SSN	Relationship ☐ Son ☐ Daughter Other